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LETTER

Practice patterns in osteoporosis prevention in patients on glucocorticoids

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Dear Editor,
We have read the recent results from the study on osteoporosis prevention in chronic (>90 days) glucocorticoid users by Feldstein et al. [1] and have three comments.

1. We believe that any apparent under-treatment may be partly due to the fact that the data analysed were collected from January 2000–December 2001. The American College of Rheumatology (ACR) guidelines for prevention of glucocorticoid-induced osteoporosis were published in July 2001 and recommended that osteoporosis prevention should be considered in those patients treated on ≥5 mg of prednisolone per day [3]. The guidelines available before this suggested that patients should be considered for osteoporosis prevention if the dose was greater than 7.5 mg per day, and the patients were treated for >6 months with the glucocorticoid [4]. We believe to be fair to the prescribers and other primary-care clinicians it should be noted that at the time that these data were collected most would only be aware that patients treated with ≥7.5 mg prednisolone should be considered for osteoporosis prevention.

2. There was no information on calcium or vitamin D (activated or non-activated) use. Were these medications/supplements excluded/not considered or unavailable? We believe these are important to mention because they were listed in the 1996 and 2001 ACR guidelines. In addition, clinical trials with bisphosphonates have included calcium/vitamin D in their protocol.

3. The authors note that their population had a high mean prednisone dose of 20mg/day. We believe that this unusually high dose of corticosteroid is due partly to their methods in calculating the "average" dose. The mean dose was obtained by using supplied quantities and not the actual dose. The authors included all medications dispensed including those during hospitalisation, which probably accounts for the high mean dose. For example, asthmatic/COPD patients (or other patients with sliding scales) with frequent admissions to hospital are likely to receive short courses of high-dose corticosteroid therapy in hospital, which will undoubtedly increase the mean dose. It would be interesting to know if these doses were excluded, and what the median (and range) dose of corticosteroid therapy was, i.e. what is the usual maintenance dose of corticosteroid? This may be an important consideration for prescribers when considering osteoporosis prevention because the correlation between daily dose and fracture is stronger than for cumulative dose [2]. Having said that, we don't expect the overall results from this study (i.e., underuse of osteoporosis prevention) would change significantly.

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